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P-IRO Inc.

Notice of Independent Review Decision

Patient Name: ***Case Number:***

Review Type: Preauthorization ***Date of Notice:*** 02/10/2015

Coverage Type: Workers Compensation Health Care Net ***IRO Certification No.:*** 5312

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Orthopedic Surgery

Description of the service or services in dispute:

Right shoulder EUA, Scope, Repair Glenoid Labrum Tear

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

The patient is a male who was injured on xx/xx/xx when a foot struck a concrete drain pry drain pipe. The patient twisted and fell injuring his right shoulder. The patient was status post right shoulder distal clavicle excision acromioplasty and rotator cuff repair on 04/01/14. The patient attended an extensive amount of post-operative physical therapy through 09/14 for over 50 sessions. The patient was followed for continuing complaints of right shoulder pain. MRI of the right shoulder from 10/14/14 noted fluid within the rotator cuff with no recurrent tears. Biceps tendon resided within the bicipital groove with intact biceps labral anchor. No displaced labral tearing or paralabral cyst was identified. Contrasted MRI of the right shoulder on 11/13/14 noted intact biceps tendon with evidence of a posterior SLAP lesion that appeared complex. The patient plateaued with physical therapy for range of motion which was still limited to 155 degrees abduction and flexion. It appeared the patient was seen for impairment rating however he was not placed at maximum medical improvement. On physical examination the patient did not demonstrate full range of motion but this was only slightly limited. There was catching and a locking feeling with rotation of the right shoulder on abduction. The proposed repair of the labrum was denied by utilization review on 11/21/14 and 12/29/14 as it was unclear whether there was a type 2 or 4 SLAP lesion for which repair was indicated. There was also no documented evidence of instability on physical examination.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

In review of the clinical documentation submitted for review the patient has follow has been followed for continuing complaints of right shoulder pain that had been extensive rehabilitated with physical therapy following the primary surgical intervention in 04/14. Based on the most recent physical examination there was good range of motion in the right shoulder with no evidence of instability. The patient had catching and locking with rotation of the shoulder. MRI showed a biceps MRI showed evidence of a SLAP lesion extending from the biceps labral complex to the superior labrum. Given the overall good function post-operatively without evidence of significant instability it is unclear at this time how further surgical intervention would serve to improve overall functional ability. There is no indication from the clinical records that the patient is having significant difficulty functioning with the current physical examination. Given the given this, it is the opinion of this reviewer that medical necessity is not established and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)